Payerpath Registration

Business name:		
Business address (include city, state and zip code:		
Business contact (first and last):		Phone:
Provider specialty:		Federal tax ID number
What is the name of your internet service provider?		
Do you currently use practice or hospital management software? ☐Yes ☐No		Do you use the web browser Internet Explorer 6.0 or higher? ☐Yes ☐No
What is your average number of Medicaid claims per month?		Which claim form do you use? ☐CMS-1500 ☐(HCFA) ☐UB ☐ADA
How many providers from your practice/business/facility will be submitting claims under this Payerpath account?		
Primary User (first and last name):		
Phone:	Fax:	E-mail:
Secondary User (first and last name):		
Phone:	Fax:	E-mail:
Tertiary User (first and last name):		
Phone:	Fax:	E-mail:

On the following lines, enter information about each provider who will be submitting claims using this Payerpath account. List each provider's name, 10-digit NPI/API and the 10-digit NPI/API of the group that provider is associated with (when applicable). Attach additional sheets if necessary to list all providers.

	Provider Name	NPI/API	Group NPI/API
1			
2			
3			
4			
5			
6			

7			
8			
9			
10			
11			
12			